UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JOY EVANS, *et al.*,

Plaintiffs,

and

UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

ADRIAN M. FENTY, *et al.*,

Defendants.

FILED
SEP 12 2007
NANCY MAYER WHITTINGTON, CLERK
U.S. DISTRICT COURT

Civil Action No. 76-293 (ESH/JMF)

ORDER

Following the quarterly status conference on August 9, 2007, the Court ordered in pertinent part, that "[t]he parties shall meet with the Special Masters to develop and submit for the Court's approval an agreed-upon order setting forth a limited number of concrete, short-term goals relating to retaining and increasing the number of qualified providers and improving the health and safety of class members." *See* Minute Order dated Aug. 15, 2007. The short-term goals included in this Order are to be achieved, unless otherwise stated, during the three-month period from October 1, 2007, to December 31, 2007. This Order shall be effective on the date signed by the Court. Nothing herein shall be construed to stay the Court's Order of March 30, 2007, or the Court Monitor's continued evaluation of the adequacy of defendants' remedial efforts. Compliance with the terms of this specific Order shall be determined by the Special Masters beginning in January 2008. The defendants agree to solicit the input of neighboring and regional jurisdictions and nearby high-quality community providers (whether or not they currently provide services in defendants' system) in order to identify and import best practices with regard to meeting the needs of persons with developmental disabilities.

Accordingly, it is hereby ORDERED as follows:

1. Retaining and Increasing the Number of Qualified Providers

a. *Cost of Living Adjustment*: In an effort to assure the continued operation of quality intermediate care facilities for persons with mental retardation ("ICF/MR"), the Department of Health's Medical Assistance Administration ("MAA") shall propose an amendment of the State Medicaid Plan and request of the U.S. Department of Health and

Human Services' Centers for Medicaid and Medicare Services ("CMS") and the Council of the District of Columbia ("Council") a cost of living adjustment for ICF/MR programs calculated to cover the actual Medicaid cost of living increases that would have been paid during the five-year period from 2003 to 2007 inclusive, such adjustment to be retroactive to October 1, 2007. The purpose of this adjustment is to provide short-term relief and provide for inflationary adjustments not awarded since 2003. The defendants estimate that the cost of living adjustment will cost approximately $15.6 million, and the Mayor has committed to work with the Council to obtain funding for the local share of $4.7 million. To the extent this estimate is not accurate, the Mayor will make efforts to obtain additional local funding and to secure the approval of the Council to ensure that such adjustment is promptly paid to IC/MR providers.

b. *Recruiting Five New Providers*: Since the status conference on August 9, 2007, the defendants have recruited and shall continue to recruit a minimum of five new qualified, Medicaid-eligible residential providers with established management and program infrastructures and the capacity to serve, at a minimum, a combined total of 25 *Evans* class members. The new providers shall meet all standards established by the Department on Disability Services ("DDS") to qualify for a Human Care Agreement ("HCA") (27 DCMR sec. 1905.5(a)-(d)), shall be a provider in good standing in the jurisdictions in which they operate, and shall have no uncorrected findings of immediate jeopardy. The defendants shall ensure that residences developed pursuant to this Order:

1. meet fire and health codes;
2. are physically accessible if needed for the individual(s) served;
3. are located close to shops, restaurants, community resources and public transportation, or there is transportation available to class members in order to access these resources; and
4. serve four or fewer class members.

In the unlikely event that there are not 25 class members willing to move into residences operated by these providers, the District's inability to comply with this provision will be excused.

c. *Streamline Provider Application Processes*: The defendants shall utilize the DDS' full authority to independently execute all HCAs, applications for services under the Medicaid Home and Community Based Waiver ("HCBW") program, and any other contractual agreements deemed necessary to comply with this Order. With the exception of Council approval for HCAs in excess of $1 million, within 15 business days of receipt of a completed HCA or HCBW application, the defendants shall complete all reviews and required decisions.

d. *Provider Technical Assistance:* Within 30 days of the effective date of this Order, defendants shall create a unit within the DDS that will provide targeted technical assistance and support to new providers to the District to assure smooth and timely start-up in obtaining appropriate licenses and executed agreements, and assistance with appropriate billing practices to obtain timely payment for services provided.

e. *Provider Incentives*: Based on demonstrated need, the defendants shall make payment to newly recruited Medicaid-eligible providers under the HCBW program, for start-up

and operational costs associated with leases, utilities, and staff training, for a period not to exceed 30 calendar days, or until the facility is licensed and/or certified as a Medicaid-eligible Waiver provider, whichever is sooner. Such start-up incentive assistance shall be limited to not-for-profit organizations with established management and program structures proven to be successful in providing these services. Within 45 calendar days of the effective date of this Order, the defendants shall publish any emergency, proposed, and final rulemaking necessary to implement this incentive assistance program. This assistance will only be in effect for 90 days from commencement thereof and only as needed to facilitate the recruitment of new providers. This pilot program will be evaluated for its effectiveness and, if determined to be effective, the defendants agree to seek the means to continue the program beyond the 90-day period.

2. Improving the Health and Safety of Class Members

a. *Support Intensity Scale Assessments*: Within 14 days of the effective date of this Order, the defendants shall adopt a methodology for identifying High Health Risk class members. By November 1, 2007, the defendants shall complete needs assessments of all *Evans* class members utilizing the Support Intensity Scale ("SIS") and shall apply the methodology for systematically identifying High Health Risk Class Members. The defendants, in collaboration with the D.C. Healthcare Resources Partnership ("DCHRP"), shall apply such methodology to update the current listing of at-risk class members. The Court Monitor shall be given an opportunity to review and give input into the methodology prior to its implementation.

b. *Improving Health Care:* The defendants, in consultation with the Court Monitor, shall, with reasonable promptness, identify up to 25 at-risk *Evans* class members from the updated list who are medically fragile or deemed to otherwise benefit from a comprehensive review of their medical and other records to determine whether diagnoses, evaluations and treatment adhere to standards of acceptable medical practice, and whether treatment and health care plans are being carried out in an appropriate and timely manner consistent with identified needs to ensure quality health care, and then take corrective action where deficiencies are found to exist. For these 25 *Evans* class members, the defendants shall organize comprehensive case reviews completed by teams comprised of professional clinical staff from the provider and professional clinical staff from the DCHRP. This team will conduct a comprehensive review of each class member's medical record, including the class member's prescribed psychotropic medications and adaptive equipment needs, if any. The team shall review diagnoses and all supporting evaluations and assessments, medication regimens, and treatment and health care plans. If deficiencies are found, the defendants shall take prompt corrective action to ensure medically appropriate treatment, and that health care plans are revised and implemented for class members. Other corrective actions may include, but not be limited to, re-training of medical and nursing personnel or transfer and placement of class member(s) to more appropriate settings and/or health care provider(s). The defendants shall evaluate the results of these comprehensive reviews, identify systemic issues that arise, review and make necessary changes to their policies and practices, and develop plans to implement systemic recommendations to prevent the recurrence of identified problems. Based on the results of the evaluation, defendants may develop a plan to continue such comprehensive reviews of pertinent class members on the at-risk list beyond the 90-day period.

c. *Physician Extender Pilot Project*: The defendants shall provide the financial support to continue the current Bread for the City clinic medical home model that the DCHRP recently piloted in collaboration with the George Washington University ("GWU") School of Medicine and Health Sciences and RCM of Washington, Inc., which has targeted 32 individuals funded through the ICF/MR. The defendants shall establish and fund a second physician extender program that impacts three additional provider organizations that serve significant numbers of *Evans* at-risk class members.

d. *Basic Assurances Standards Authorization ("BASA")*: The defendants shall complete, at a minimum, initial BASA reviews of all current community-based residential providers serving *Evans* class members. The DDS shall not make any additional placements to community based residential programs that fail the initial and second round BASA reviews. For those providers that fail the third round BASA review, the defendants shall initiate proceedings to revoke the provider's HCA, shall notify the Health Regulation Agency ("HRA"), and shall, consistent with choice and appropriate transition planning, transfer *Evans* class members and other consumers from the provider to other more appropriate settings. For new providers, the defendants shall complete an initial BASA review within 60 days of commencing service delivery.

e. *Poorly Performing Providers*: During the period of the BASA review, the defendants shall identify those community programs and providers whose performance is not at acceptable levels and/or pose a potential risk of harm to *Evans* class members. The defendants shall establish and publish criteria as follows: (1) any provider/site responsible for substantiated incidents in the five serious reportable incident areas of abuse, neglect, serious physical injury, serious medical error and theft of personal property; (2) any HRA provider/site with enforcement actions, conditions of participation, immediate jeopardy, or recommendations for termination in the past 24 months or two surveys; or (3) any provider/site where the Court Monitor has made findings of serious deficiencies affecting health and safety, and has notified the provider and the DDS in writing of such findings. Providers that meet these criteria will be placed on a "Watch List," and the provider will be required to develop a Plan of Correction within five business days, with measurable short-term corrective actions, which will be monitored and enforced by the defendants. For those providers that fail to develop or fully implement a Plan of Correction, the defendants shall initiate proceedings to revoke the provider's HCA, shall notify HRA, and shall, consistent with choice and appropriate transition planning, transfer *Evans* class members and other consumers from the provider to another more appropriate setting.

f. *Guardianships for Health-Care Decision-making*: The defendants shall continue to prioritize the appointment of permanent health-care guardians for *Evans* class members and other consumers. For emergency circumstances that do not meet the requirements of D.C. Official Code § 21-2212(c), the defendants shall, within three business days of an identified need for emergency care, file a petition with the Probate Court for appointment of a temporary emergency guardian. For purposes of this provision, the term "emergency" or "emergency care" shall mean "immediate treatment, including diagnostic treatment, provided in response to a sudden, acute, and unanticipated medical crisis in order to avoid injury, extreme pain, impairment, or death" as defined in D.C. Official Code § 21-2011(5C). In addition, for circumstances that do not rise to the level of an emergency as defined above, but nevertheless

require expedited consideration, the defendants shall, within ten business days of an urgent and identified need, file a petition with the Probate Court for appointment of a permanent, limited guardian. The defendants shall implement a training program for case managers, residential providers, and health-care and other medical service providers to educate them on the current legal requirements for substitute health-care decision-making, and the processes and procedures for obtaining the timely appointment of a permanent health-care guardian or temporary emergency guardian, and where necessary, the use of D.C. Official Code § 21-2212(c) where consent is not reasonably available.

g. *Investigations Training*: The defendants shall retain Labor Relations Alternatives, Inc. to provide training and certification of investigators for all current, Medicaid-eligible providers of residential services for *Evans* class members. Defendants shall amend the format for IMEU investigation reports to add a section requiring the investigator to identify factors potentially causing or contributing to the occurrence of the incident investigated, and formulating recommendations for prevention or correction of any identified problems.

h. *Mortality Investigations.* The defendants agree to implement the following recommendations emanating from mortality investigations. For recommendations which require actions by provider agencies, defendants agree to use their full licensing, funding and enforcement authority to require provider agencies to implement these recommendations. If a provider agency fails to implement these recommendations, the defendants agree to use these authorities to impose suitable sanctions, including revocation of HCAs, termination of Medicaid provider agreements and, consistent with choice and appropriate transition planning, transfer *Evans* class members and other consumers from the provider to other more appropriate settings.

1. Case No. 06-0772, recommendation #6. Both DDS and the provider serving RW will have protocols in place to ensure that individuals presenting with ongoing functional and health decline receive adequate evaluation in a timely manner in an effort to identify the etiology of the problem(s) and that Interdisciplinary Teams closely monitor these individuals, develop appropriate action plans/interventions, and revise the ISPs as indicated.

2. Case No. 06-0772, recommendation #10. The provider serving RW should ensure that procedures/processes are in place to ensure that staff with oversight responsibilities for care plans clearly document periodic monitoring of care plan implementation to include observations, objective progress toward goals, review of data, and recommendation for improvement, plan revisions as indicated, staff training, etc.

3. Case No. 07-0314, recommendation #10. The provider serving JN should ensure that medication side effects and drug-to-drug interactions are monitored and considered in relation to an individual's presenting health issues. This would include ensuring that drug regimen reviews completed by the pharmacist are comprehensive.

4. Case No. 07-0223, recommendation #5. DDS should develop guidelines for psychiatric care consistent with contemporary standards that encourage:

a. Comprehensive psychiatric assessments of individuals especially those with cognitive/mental status decline that include consideration of organic causes prior to instituting psychoactive medication therapy.

b. Clinical rationale/evidence for new psychiatric diagnoses and/or changes in the level of an individual's mental retardation.

c. Documentation of the clinical rationale for all therapeutic decisions including objective data to support decisions.

d. Clearly defined symptoms/behaviors that should be tracked in order to monitor the efficacy of the decisions.

e. Changing only one medication at a time unless a clear clinical rationale to do otherwise is documented.

f. Routine monitoring especially after new medications are initiated or dosages changed.

5. Case No. 07-0016, recommendation #2. The provider serving TW will ensure that there is a process in place to ensure that individuals are routinely monitored for adverse effects of medications and potential drug-to-drug interactions. Adverse side effects and drug-to-drug interactions should always be considered in the presence of behavioral episodes and somatic complaints.

SO ORDERED.

Ellen S Huvelle

HON. ELLEN SEGAL HUVELLE
United States District Judge

Date: September 12, 2007